

Facility Name & ID Number Granite Nursing & Rehabilitation Center

0046904 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	86	Skilled (SNF)	86	31,390	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,345	8,217	6,066	29,628	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,345	8,217	6,066	29,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.39%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

outpatient therapy

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1/1/05

J. Was the facility purchased or leased after January 1, 1978?

YES Date January 1, 2005 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 86 and days of care provided 4,555

Medicare Intermediary Wisconsin Physicians Insurance Corp. (WPS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 1/1 to 12/31/10 Fiscal Year: 1/1 to 12/31/10

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Granite Nursing & Rehabilitation Center # 0046904 Report Period Beginning: 1/1/10 Ending: 12/31/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	174,539	22,326	10,896	207,761		207,761	(1,092)	206,669		1
2	Food Purchase		179,433		179,433		179,433	(290)	179,143		2
3	Housekeeping	123,514	14,840		138,354		138,354		138,354		3
4	Laundry	34,373	11,774		46,147		46,147		46,147		4
5	Heat and Other Utilities			121,563	121,563		121,563		121,563		5
6	Maintenance	21,965	13,922	55,908	91,795		91,795	(17,360)	74,435		6
7	Other (specify):* see trial balance			18,516	18,516		18,516		18,516		7
8	TOTAL General Services	354,391	242,295	206,883	803,569		803,569	(18,742)	784,827		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,617,796	121,040	45,208	1,784,044		1,784,044	5,240	1,789,284		10
10a	Therapy		4,711	1,149,252	1,153,963		1,153,963	(251,167)	902,796		10a
11	Activities	32,690	843	3,192	36,725		36,725		36,725		11
12	Social Services	31,993	475	1,474	33,942		33,942		33,942		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* see trial balance			24,142	24,142		24,142	(8,224)	15,918		15
16	TOTAL Health Care and Programs	1,682,479	127,069	1,232,868	3,042,416		3,042,416	(254,151)	2,788,265		16
	C. General Administration										
17	Administrative	208,340		297,156	505,496		505,496	(84,943)	420,553		17
18	Directors Fees										18
19	Professional Services			17,188	17,188		17,188	(2,159)	15,029		19
20	Dues, Fees, Subscriptions & Promotions			21,447	21,447		21,447	(7,435)	14,012		20
21	Clerical & General Office Expenses		29,627	26,712	56,339		56,339	(5,165)	51,174		21
22	Employee Benefits & Payroll Taxes			454,603	454,603		454,603	(4,411)	450,192		22
23	Inservice Training & Education										23
24	Travel and Seminar			25,375	25,375		25,375	(61)	25,314		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			142,236	142,236		142,236	(2,600)	139,636		26
27	Other (specify):* see trial balance			68,152	68,152		68,152	(47,995)	20,157		27
28	TOTAL General Administration	208,340	29,627	1,052,869	1,290,836		1,290,836	(154,769)	1,136,067		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,245,210	398,991	2,492,620	5,136,821		5,136,821	(427,662)	4,709,159		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Granite Nursing & Rehabilitation Center

#0046904

Report Period Beginning:

1/1/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			422,658	422,658		422,658	10,511	433,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			85,940	85,940		85,940	(1,787)	84,153			33
34	Rent-Facility & Grounds			100,097	100,097		100,097		100,097			34
35	Rent-Equipment & Vehicles			49,326	49,326		49,326		49,326			35
36	Other (specify):*											36
37	TOTAL Ownership			658,021	658,021		658,021	8,724	666,745			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			524	524		524		524			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):* see trial balance			181,386	181,386		181,386	(42,753)	138,633			43
44	TOTAL Special Cost Centers			228,995	228,995		228,995	(42,753)	186,242			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,245,210	398,991	3,379,636	6,023,837		6,023,837	(461,691)	5,562,146			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients	(15,681)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(70)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(867)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(215)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(413)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(116)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,669)	27		24
25	Fund Raising, Advertising and Promotional	(7,435)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(54,762)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (124,228)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(337,463)	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (337,463)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (461,691)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Granite Nursing & Rehabilitation Center

ID# 0046904

Report Period Beginning: 1/1/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable EE Recognition Program	\$ (1,094)	22	1
2	Remove Non-allowable Employee Benefits	(312)	22	2
3	Remove Non-allowable Visa Costs	(61)	24	3
4	Remove Non-allowable Visa Costs	(470)	22	4
5	Remove Non-allowable Admiss - Other Supplies	(4,295)	21	5
6	Remove Non-allowable Insurance Costs	(2,600)	26	6
7	Remove Non-allow Outpatient Svcs-Consol Billing	(64)	43	7
8	Remove Non-allowable Nrs Admin- Purch Svcs	(6,322)	15	8
9	Remove Non-allowable Acctg - Tax Fees	(2,043)	19	9
10	Remove Non-allowable Admin- Purch Services	(2,913)	27	10
11	Remove Non-allowable Prior Year Costs	(7,044)	43	11
12	Remove Non-allowable IV Prescription Drugs	(5,879)	43	12
13	Amort/Depreciate Repair/Maint Captl. For Medicaid	10,511	30	13
14	Remove Real Estate Tax Under/(Over) Accrual	(1,787)	33	14
15	Offset Interco Sold Services Revenue	(897)	10	15
16	Offset Interco Sold Services Revenue	(18)	6	16
17	Offset Interco Sold Services Revenue	(585)	10	17
18	Offset Interco Sold Services Revenue	(1,010)	10	18
19	Offset Interco Sold Services Revenue	(248)	17	19
20	Offset Interco Sold Services Revenue	(1,120)	22	20
21	Remove Interco Purchased Services Mark-up	(1,707)	15	21
22	Remove Interco Purchased Services Mark-up	(1,092)	1	22
23	Remove Capitalized Repairs & Maintenance	(17,342)	6	23
24	Offset Misc. Revenue	(572)	10	24
25	Offset Misc. Revenue	(56)	10	25
26	Offset Misc. Revenue	(404)	10	26
27	Offset Misc. Revenue	(19)	10	27
28	Offset Misc. Revenue	(3)	21	28
29	Offest Misc. Revenue	(5)	2	29
30	Offest Outpatient Occupational Therapy Revenue	(5,311)	10a	30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(54,762)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nursing & Rehabilitation Center

0046904

Report Period Beginning:

1/1/10

Ending:

12/31/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,092)	0	0	0	0	0	0	0	0	0	0	(1,092)	1
2	Food Purchase	(290)	0	0	0	0	0	0	0	0	0	0	(290)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(17,360)	0	0	0	0	0	0	0	0	0	0	(17,360)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,742)	0	0	0	0	0	0	0	0	0	0	(18,742)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,543)	8,783	0	0	0	0	0	0	0	0	0	5,240	10
10a	Therapy	(20,992)	(230,175)	0	0	0	0	0	0	0	0	0	(251,167)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(8,029)	(195)	0	0	0	0	0	0	0	0	0	(8,224)	15
16	TOTAL Health Care and Programs	(32,564)	(221,587)	0	(254,151)	16								
	C. General Administration													
17	Administrative	(248)	(84,695)	0	0	0	0	0	0	0	0	0	(84,943)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,159)	0	0	0	0	0	0	0	0	0	0	(2,159)	19
20	Fees, Subscriptions & Promotions	(7,435)	0	0	0	0	0	0	0	0	0	0	(7,435)	20
21	Clerical & General Office Expenses	(5,165)	0	0	0	0	0	0	0	0	0	0	(5,165)	21
22	Employee Benefits & Payroll Taxes	(2,996)	(1,415)	0	0	0	0	0	0	0	0	0	(4,411)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(61)	0	0	0	0	0	0	0	0	0	0	(61)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	26
27	Other (specify):*	(47,995)	0	0	0	0	0	0	0	0	0	0	(47,995)	27
28	TOTAL General Administration	(68,659)	(86,110)	0	(154,769)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(119,965)	(307,697)	0	(427,662)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nursing & Rehabilitation Center# 0046904

Report Period Beginning:

1/1/10

Ending:

12/31/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	10,511	0	0	0	0	0	0	0	0	0	0	10,511	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(1,787)	0	0	0	0	0	0	0	0	0	0	(1,787)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,724	0	0	0	0	0	0	0	0	0	0	8,724	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(12,987)	(29,766)	0	0	0	0	0	0	0	0	0	(42,753)	43
44	TOTAL Special Cost Centers	(12,987)	(29,766)	0	(42,753)	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(124,228)	(337,463)	0	0	0	0	0	0	0	0	0	(461,691)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See attached schedule detailing information for Schedule VII, Section A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Administrative Services Costs	\$ 297,156	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 212,461	\$ (84,695)	1
2	V	34 Sublease Building & Equip	100,097	Tara Midwest, LLC	0.00%	100,097		2
3	V	15 Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	3,405	(195)	3
4	V	10 Pharmacy Consulting Services	18,576	Tara Pharmacy SE, LLC	0.00%	26,797	8,221	4
5	V	43 Flu Vac/Prescription Drug- Residents	134,551	Tara Pharmacy SE, LLC	0.00%	104,785	(29,766)	5
6	V	22 Flu & Hep B Vaccine for Employees	5,718	Tara Pharmacy SE, LLC	0.00%	4,303	(1,415)	6
7	V	10 Medication Administration Records	5,676	Tara Pharmacy SE, LLC	0.00%	6,238	562	7
8	V	10a Physical Therapy Fees	387,607	Tara Therapy, LLC	0.00%	301,963	(85,644)	8
9	V	10a Occupational Therapy Fees	510,371	Tara Therapy, LLC	0.00%	407,381	(102,990)	9
10	V	10a Speech Therapy Fees	249,475	Tara Therapy, LLC	0.00%	207,934	(41,541)	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,712,827			\$ 1,375,364	\$ * (337,463)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Granite Nursing & Rehabilitation Center # 0046904 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00	0	0	0.00	0	\$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/Admin	0.00	***	0.7	0.02	Fin/Adm.	4,720	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/Admin	0.00	***	0.7	0.02	Fin/Adm.	4,720	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.7	0.02	VP	3,852	17	7
8											8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										
10											10
11											11
12											12
13								TOTAL	\$ 13,292		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Granite Nursing & Rehabilitation Center

0046904

Report Period Beginning:

1/1/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Aurora Cares, LLC d/b/a Tara Cares
 Street Address PO Box 428
 City / State / Zip Code Orchard Park, NY 14127
 Phone Number (716)662-4955
 Fax Number (716)662-2529

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Administrative Services Costs	Days	1,418,531	36	\$ 253,727	\$ 241,032	29,615	\$ 5,297	1
2	5	Administrative Services Costs	Days	1,418,531	36	36,729	0	29,615	767	2
3	6	Administrative Services Costs	Days	1,418,531	36	57,523	1,453	29,615	1,201	3
4	10	Administrative Services Costs	Days	1,418,531	36	879,684	771,995	29,615	18,365	4
5	17	Administrative Services Costs	Days	1,418,531	36	6,601,121	6,601,121	29,615	137,811	5
6	19	Administrative Services Costs	Days	1,418,531	36	106,999	0	29,615	2,234	6
7	20	Administrative Services Costs	Days	1,418,531	36	10,087	0	29,615	211	7
8	21	Administrative Services Costs	Days	1,418,531	36	287,981	0	29,615	6,012	8
9	22	Administrative Services Costs	Days	1,418,531	36	1,344,595	0	29,615	28,071	9
10	24	Administrative Services Costs	Days	1,418,531	36	100,686	0	29,615	2,102	10
11	26	Administrative Services Costs	Days	1,418,531	36	6,260	0	29,615	131	11
12	27	Administrative Services Costs	Days	1,418,531	36	134,804	0	29,615	2,814	12
13	30	Administrative Services Costs	Days	1,418,531	36	213,053	0	29,615	4,448	13
14	31	Administrative Services Costs	Days	1,418,531	36	10,497	0	29,615	219	14
15	33	Administrative Services Costs	Days	1,418,531	36	27,056	0	29,615	565	15
16	34	Administrative Services Costs	Days	1,418,531	36	105,664	0	29,615	2,206	16
17	35	Administrative Services Costs	Days	1,418,531	36	351	0	29,615	7	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,176,817	\$ 7,615,601		\$ 212,461	25

Facility Name & ID Number

Granite Nursing & Rehabilitation Center

0046904

Report Period Beginning:

1/1/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	83,640	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	81,853	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,787)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	85,940	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	84,153	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	65,885		8
	2006	68,397		9
	2007	70,786		10
	2008	79,663		11
	2009	81,853		12
The 2010 assessment was estimated to be a 5% increase over the 2009 assessment.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Granite Nursing & Rehabilitation Center

0046904

Report Period Beginning:

1/1/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,856 B. General Construction Type: Exterior Brick Frame Number of Stories one

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 639,907 2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)

3. Current Period Amortization: Included in Schedule VII B Ln 1-8 4. Dates Incurred: Various and on the books of the related entities.

Nature of Costs: Inc.capitalized pre-opening salaries, fringe benefits & other costs incurred prior 1/1/06.Costs allocated via related org cost & reported on Sch V (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 contains 'TOTALS'.

Facility Name & ID Number Granite Nursing & Rehabilitation Center

0046904

Report Period Beginning:

1/1/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Plumbing and Mechanical repairs capitalized for Medicaid	2005		7,645		3			7,645	9
10		Paint - Kitchen	2006		4,500	900	5	900		4,050	10
11		Paint Center of Building	2006		37,005	7,401	5	7,401		33,304	11
12		Window Treatment	2006		5,089	1,018	5	1,018		4,580	12
13		20 Ton HVAC Unit	2006		20,160	2,016	10	2,016		9,072	13
14		Sprinkler System	2006		232,098	19,341	12	19,341		87,037	14
15		Emergency Lighting	2006		2,034	169	12	169		763	15
16		Weatherproof Lighting	2006		5,470	456	12	456		2,051	16
17		Exhaust Hood	2006		8,017	668	12	668		3,006	17
18		Sign	2006		800	80	10	80		360	18
19		Utility Room Cabinet	2006		2,946	246	12	246		1,105	19
20		Plumbing and Mechanical repairs capitalized for Medicaid	2006		16,108		3			16,108	20
21		2 Sprinkler System Heads	2007		1,578	143	11	143		502	21
22		Concrete Sidewalk	2007		2,470	247	10	247		865	22
23		Mag Locks and Key Pads	2007		2,604	260	10	260		911	23
24		Physical Therapy Addition	2007		431,389	39,217	11	39,217		137,260	24
25		Plumbing and Mechanical repairs capitalized for Medicaid	2007		20,861	3,477	3	3,477		20,861	25
26		Generator	2007		146,483	29,297	5	29,297		73,241	26
27		Mechanical/Electrical Systems Upgrade & Significant Bldg Improvements	2008		1,623,449	162,345	10	162,345		405,862	27
28		-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrails									28
29		Dry Pendants	2008		3,020	302	10	302		755	29
30		Window Treatments	2008		30,741	6,148	5	6,148		15,370	30
31		Mechanical/Electrical Systems Upgrade & Significant Bldg Imprvmnts- Stg 2	2008		882,074	88,207	10	88,207		220,519	31
32		-call system, wardrobes, flooring, door handles/locks, cubicle curtains/track									32
33		Facility Sign	2008		12,836	1,284	10	1,284		3,209	33
34		Roof	2008		132,870	13,287	10	13,287		33,218	34
35		Physical Therapy Costs capitalized for Medicaid	2008		6,100	2,033	3	2,033		5,083	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Sewer Ejector Pump	2009	\$ 9,950	\$ 1,105	9	\$ 1,105	\$	\$ 1,658	37
38 Boiler Assessment (Asset #120 Addition)	2009	11,439	1,271	9	1,271		1,907	38
39 Satellite TV Equipment	2009	12,830	1,426	9	1,426		2,138	39
40 Garage Door	2009	662	74	9	74		110	40
41 Generator and Carrier Air Handler rpr Capitalized for Medicaid	2009	6,331	2,111	3	2,111		3,166	41
42 Boiler System Replacement	2010	73,440	4,590	8	4,590		4,590	42
43 A/C Unit (4)	2010	2,291	229	5	229		229	43
44 Boiler system repairs and concrete repairs to exits/stairwells								44
45 Capitalized for Medicaid	2010	17,342	2,890	3	2,890		2,890	45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65 Note: See additional building improvements made by property								65
66 owner Healthcare REIT, Inc. on supplemental schedule								66
67 included as Page 24 of the cost report.								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,772,630	\$ 392,238		\$ 392,238	\$	\$ 1,103,425	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 305,086	\$ 38,656	\$ 38,656	\$	various	\$ 138,114	71
72	Current Year Purchases	31,122	2,275	2,275		various	2,275	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 336,208	\$ 40,931	\$ 40,931	\$		\$ 140,389	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,108,838	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 433,169	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 433,169	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,243,814	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	no CIP at 12/31/10	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Health Care REIT, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1964</u>	<u>86</u>	<u>1/1/05</u>	\$ <u>100,097</u>	<u>13.5</u>	<u>1-15 yr.</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>86</u>		\$ <u>100,097</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: 60 day notice - see attached *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 59,183 Description: See separate schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>See separate schedule</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 01/01/2005

Ending 06/30/2018

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2011 \$ 100,097

13. 12/31/2012 \$ 100,097

14. 12/31/2013 \$ 100,097

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Granite Nursing & Rehabilitation Center

0046904

Report Period Beginning: 1/1/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 90,755	\$	1
2	Cash-Patient Deposits	23,037		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	499,824		3
4	Supply Inventory (priced at <u>cost</u>)	4,674		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,220		6
7	Other Prepaid Expenses	24,822		7
8	Accounts Receivable (owners or related parties)	(2,459,330)		8
9	Other(specify): <u>Non resident A/R (see TB)</u>	2,050		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,812,948)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,698,243		15
16	Equipment, at Historical Cost	336,208		16
17	Accumulated Depreciation (book methods)	(1,188,061)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(69)		21
22	Other Long-Term Assets (spe <u>Deposits long term</u>)	1,100		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,847,421	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,034,473	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 63,960	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,735		28
29	Short-Term Notes Payable	4,495		29
30	Accrued Salaries Payable	144,977		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,883		31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,940		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Employee Benefits Payable</u>	7,826		36
37	<u>Accrued Expenses</u>	618,391		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 970,207	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due To/From HC REIT</u>	501,857		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 501,857	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,472,064	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (437,591)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,034,473	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (221,134)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (221,134)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	67,422	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(283,879)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (216,457)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (437,591)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,672,929	1
2	Discounts and Allowances for all Levels	1,434,046	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,106,975	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	20,992	5
6	Therapy	949,159	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 970,151	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	70	14
15	Telephone, Television and Radio	1,800	15
16	Rental of Facility Space		16
17	Sale of Drugs	970	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,154	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,994	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,970	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,970	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	139	28
28a	Prch Disc / Vending Commissions / Sold Srvc Rev	6,030	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,169	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,091,259	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	803,569	31
32	Health Care	3,042,416	32
33	General Administration	1,290,836	33
	B. Capital Expense		
34	Ownership	658,021	34
	C. Ancillary Expense		
35	Special Cost Centers	181,910	35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,023,837	40
41	Income before Income Taxes (line 30 minus line 40)**	67,422	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 67,422	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? See attached If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Granite Nursing & Rehabilitation Center

0046904

Report Period Beginning:

1/1/10

Ending:

12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,584	2,861	\$ 110,326	\$ 38.56	1
2	Assistant Director of Nursing	2,366	2,598	48,520	18.68	2
3	Registered Nurses	3,382	3,691	84,707	22.95	3
4	Licensed Practical Nurses	29,531	31,485	648,535	20.60	4
5	CNAs & Orderlies	56,005	60,557	607,968	10.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,911	2,061	21,241	10.31	9
10	Activity Assistants	1,240	1,328	11,449	8.62	10
11	Social Service Workers	1,976	2,163	31,993	14.79	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,068	31,517	15.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,671	8,418	70,025	8.32	15
16	Dishwashers	7,800	8,672	72,997	8.42	16
17	Maintenance Workers	1,632	1,831	21,965	12.00	17
18	Housekeepers	12,634	13,802	123,514	8.95	18
19	Laundry	3,235	3,618	34,373	9.50	19
20	Administrator	4,049	4,182	115,446	27.61	20
21	Assistant Administrator					21
22	Other Administrative	1,857	1,905	30,399	15.96	22
23	Office Manager	1,920	2,056	39,480	19.20	23
24	Clerical	1,926	2,118	23,015	10.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS Coordinator	2,428	2,667	75,902	28.46	32
33	Other(specify) <u>Nrsg Admin Cleric</u>	3,483	3,887	41,838	10.76	33
34	TOTAL (lines 1 - 33)	149,598	161,968	\$ 2,245,210 *	\$ 13.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	216	9,600	9-3	36
37	Medical Records Consultant	45	2,769	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18/bed	18,576	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,474	11-3	44
45	Social Service Consultant	24	1,474	12-3	45
46	Other(specify)				46
47	<u>Medical Records Preparation</u>	\$5.50/bed	5,676	10-3	47
48					48
49	TOTAL (lines 35 - 48)	309	\$ 39,569		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	167	\$ 18,187	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	167	\$ 18,187		53

Facility Name & ID Number Granite Nursing & Rehabilitation Center

0046904

Report Period Beginning:

1/1/10

Ending:

12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$1,779 net of non-allowable
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,275 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 47,085
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes-outpatient therapy For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 70
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC

0046904

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1			\$	\$		\$	\$	\$	1
2	Improvements Made by Landlord (covered by rent at outset								2
3	of Change of Ownership)								3
4									4
5	Aspire Telephone System	2005	7,542	754	10	754		4,148	5
6	Garage Door	2005	536	53	10	53		295	6
7	Ductwork Removal & Installation	2005	10,635	818	13	818		4,499	7
8	Replace Plumbing & Garbage Disposal	2005	6,767	520	13	520		2,863	8
9	Exhaust Fan - Laundry Area	2005	855	86	10	86		470	9
10	Doors (6)	2005	6,800	523	13	523		2,877	10
11	Air Conditioning Units (3)	2005	3,294	329	5	329		3,294	11
12	Carpeting	2005	587	59	5	59		587	12
13	Roof Repairs - New Gutters and Facia	2005	4,850	485	10	485		2,668	13
14	Fire Damper	2005	1,250	125	10	125		687	14
15	Pave Walkway	2005	5,714	714	8	714		3,928	15
16	Replace 140' Sewer & Floor	2005	39,530	3,041	13	3,041		16,724	16
17	Floor Replacement Cost @ 6/30/06	2006	17,434	1,320	10	1,320		5,939	17
18	Floor Replacement Adtl Cost Post 6/30/06	2006	(4,237)					11,875	18
19	Walk-in Cooler / Freezer	2006	31,667	2,639	12	2,639		3,462	19
20	Paint Exterior of Facility	2006	3,847	769	5	769		6,938	20
21	Plumbing Install Sinks (2)	2006	18,500	1,542	12	1,542		1,475	21
22	Carpeting	2006	1,639	328	5	328			22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 157,209	\$ 14,105		\$ 14,105	\$ 0	\$ 72,729	34

**Improvement type must be detailed in order for the cost report to be considered complete.